

No. 2
M-5-43
7-5-17-39
X38677

FILED MAR 28 1945

State File No. _____
Registrar's No. **2523**

Registration District No. **318** Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
5052 Waterman Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 006
15

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5052 Waterman Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frieda Rohlfing

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 21
year 1945 hour 10 minute 10 A. M.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Charles Rohlfing

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Mar. 6 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 28, 1945, to March 31, 1945.

that I last saw her alive on March 20, 1945. 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia
Duration From _____ to _____
March 1, 1945

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>0</u>	<u>15</u>	hr. _____ min. _____

Due to _____

Due to _____

Other conditions Chronic Subcutaneous Degeneration ?
(Include pregnancy within 3 months of death)

9. Birthplace St. Louis Mo. 11
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

MOTHER, FATHER

12. Name Chrost Vahle

13. Birthplace Germany U
(City, town, or county) (State or foreign country)

14. Maiden name Anna Beshendorf

15. Birthplace Germany U
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

16. (a) Informant Dr. Charles Rohlfing

(b) Address 5052 Waterman Ave.

17. (a) Burial (b) Date thereof 3-24-45
(Burial, cremation; or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

While at work? _____
(Specify type of place)

(g) Means of injury _____

23. Signature H. G. Beckmann (M. D. or other) D.C.
Address 3530 Brown Ave. Date signed Mar. 27 1945

18. (a) Signature of funeral director Drehmann-Harral

(b) Address 1905 Union Blvd.

19. (a) MAR 22 1945 (b) J. F. Bredenk
(Date received local registrar) (Registrar's signature)

3530 Gravois Ave.
9 to 11 & 4 to 8

STATEMENT BY LICENSED EMBALMER -

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.